STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215268	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Airy Nursing and Rehab Center	4101 Baltimore National Pike Mount Airy, MD 21771

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on interview and record review it was determined that the facility failed to provide activities for residents. This was evident for five residents (R #44, #45, #47, #50, #53) of seven residents reviewed for Activities during the recertification survey.The findings include:The findings include:On 8/25/2025 at 1:17 PM an interview was conducted with the Activities Director (Staff #20) and the Nursing Home Administrator (NHA). Staff #20 said the activities program at the facility offered mental stimulation, creative expression and physical activity, and that these were provided in both group and individual settings, depending on the residents' needs and preferences. She further described that for residents who don't like group activities or for residents who have dementia the activity staff would try different activities to see what each resident enjoyed the most. She gave examples of music, talking, and tactile activities. When asked how activity participation was tracked, Staff #20 said she kept an activities binder, and she left to retrieve it.On 8/26/25 at 11:00 AM a review of the facility's activities tracking binder revealed blank pages for 5 residents (R #44, #45, #47, #50, #53). On each individual resident's page, the heading indicated the resident's name and that the resident should have weekly one to one activity. There were no activities logged on any of the pages and no documentation of any refusal or unavailability.On 8/26/2025 at 1:57 PM another interview with Staff #20 and the NHA was conducted to review the activities documentation. When Staff #20 was shown the blank forms for the Residents #44, #45, #47, #50, #53, she responded that the activities staff had been inconsistent with their documentation but she confirmed that there was no evidence that any activities were provided to those residents.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to 1) Ensure medications and treatment supplies were secured and stored properly for 4 of 6 medication/treatment carts observed, 2) Discard medications per manufacturer's instructions when opened beyond the recommended timeframe, and 3) Ensure staff consistently followed facility policy and practice for securing medication/treatment carts during the annual recertification survey.The findings include: 1) On [DATE] at 12:03 PM , during an observation of the nursing unit during meal time and tray distribution, it was observed that a treatment cart was unlocked and unattended in front of the nurses' station adjacent to resident room [ROOM NUMBER] in the A building. The surveyor stood nearby, observing for approximately 6 minutes. The drawers opened, revealing supplies that were visible and accessible, including shears, over-the-counter topical medications, and adhesives. Staff Nurse #15 approached when they realized the cart was accessible to the surveyor. At 12:09 PM, Staff Nurse #15 on the unit approached the surveyor who was at the treatment cart. They confirmed it was unlocked, retrieved what was needed from the cart, and walked away. Later, at 12:19 PM, still in the A building during lunchtime and meal tray distribution, an observation of the medication cart near room [ROOM NUMBER] revealed it to be unlocked and unattended. Resident #62 was out of their room, walking in the hallway near the cart. The cart was observed for approximately four minutes with the surveyor opening drawers, exposing resident medication blister packages, until it was noticed by Staff Nurse #15, who quickly came and stated, Sorry! On [DATE] at 12:30 PM, the unit manager, Staff Nurse #16, for A building, was notified of the observation. At 4:09 PM, on the same day, during an Observation of B building, it was observed that one of the two treatment carts for the unit near the nursing station was unlocked and accessible. Resident #46 was nearby in the hallway. Staff Nurse #17 promptly intervened and locked the cart with the surveyor's presence. On [DATE] at 4:20 PM, the Director of Nursing was made aware of observations of unlocked carts at this time. Cross-reference and refer also to CMS F689. 2) On [DATE] at 10:38 AM, an inspection of the medication cart in building “A” assigned to Licensed Practical Nurse (LPN #6) was conducted. During the inspection, an inhaler (Fluticasone Propionate and Salmeterol inhalation powder 250mcg/50 mcg) for Resident #29 was observed to have an open date of [DATE]. Further review of the inhaler packaging revealed instructions to discard the inhaler 1 month after opening. A review of Resident #29's electronic Medication Administration Record (eMAR) for [DATE] was conducted on [DATE] at 10:52 AM. The review revealed that the inhaler was scheduled for 2 times daily (AM and PM) with the AM dose marked as already administered for [DATE] by LPN #6. Resident #29's inhaler was reviewed with LPN #6 and he confirmed the open date and indicated that it should have been discarded already based on the manufacturer's instructions. He also reported that he had already called the pharmacy around 10 AM and that the inhaler would most likely be delivered later (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	today. The eMAR of Resident #29 was being reviewed with LPN #6 and he reported that he did not administer the AM dose when he found out that the medication was already expired. During this time at 11:03 AM, the Director of Nursing (DON) walked in the nursing unit. The DON was asked to look at the resident's eMAR and she confirmed that LPN #6 documented that he administered the AM dose. The DON was asked what her expectation was from staff when a medication has instruction to discard after 1 month. The DON indicated that the facility's practice was to discard medications after 30 days and reported that in the case of Resident #29's inhaler with an open date of [DATE], it should have been discarded on [DATE]. 3) On [DATE] at 3:19 PM, an observation was made in the hallway of Building A. A treatment cart was seen in front of the nursing station. The cart was unlocked, and its doors could be easily opened. No nursing staff were observed nearby. At 3:20 PM on [DATE], Nurse Staff #9 approached the surveyor and the cart. During a brief interview, Staff #9 stated he had just come on shift and had not yet used the treatment cart. He immediately locked the cart. At 3:22 PM on [DATE], Nurse Staff #9 and the surveyor observed the cart's contents. The cart contained, but was not limited to, scissors in the top drawer and a bottle of Dakin's solution in the bottom drawer. Note: Dakin's solution is diluted bleach (sodium hypochlorite) used to clean wounds and prevent infection. At 4:01 PM on [DATE], the Administrator and Director of Nursing (DON) were informed of the unlocked and unattended treatment cart. Both confirmed that it is their expectation for medication and treatment carts to remain locked when unattended. They reported that staff re-education had begun. [DATE] 10:41 AM Administrators provided the facility policy titled “Policy #4.1 Storage of Medications.” Review of the policy revealed that medication and biologicals were to be stored safely, securely and properly following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review, observation, and interview it was determined that the facility failed to accurately assess residents' dental status. This was evident for one resident (Resident #69) of one resident reviewed for dental care during the recertification survey.The findings include:A review of Resident #69's nursing admission assessment dated [DATE] stated no oral concerns in section 3B Oral Status. In the same section there were questions to indicate if the resident had no teeth, or had broken or missing teeth, but none of those questions were answered.On 8/20/2025 at 11:25 AM Resident #69 was observed and interviewed in their room. The resident was seated in a wheelchair next to their bed, and was able to respond to questions but they had a soft voice and were difficult to understand. No teeth were observed in the resident's mouth, and when asked, the resident said they had no teeth. They said they had dentures, but they did not know where the dentures were. When asked if they were able to eat the food provided, they did not give a specific answer.On 8/27/2025 at 10:25 AM a joint observation and interview of Resident #69 was conducted with the Director of Nursing (DON) at the resident's bedside. The DON looked in the resident's mouth and determined that the resident did not have any teeth. She also said that the nursing documentation should have described that. On 8/27/2025 at 11:17 AM an interview was conducted with the Nursing Home Administrator (NHA) to review the finding that Resident #69's dental assessment was inaccurate, and she acknowledged the deficiency. No further evidence was provided by the end of the survey.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews and interviews, it was determined that the facility failed to ensure medication errors were below 5% during the medication administration observation. This was evident for 2 of 29 medications administered during the observation.The findings include: The medication administration task started on 8/28/25 at 8:04 AM. A total of 29 opportunities for errors were observed between 2 Licensed Practical Nurses (LPN #18 and #19). During the observation, the following concerns were identified:1) On 8/28/25 at 8:16 AM, LPN #18 was observed during her medication administration to Resident #51. Included in the medications that she administered was Geri-Kot (Sennosides 8.6 mg) to the resident.A review of Resident #51's medical orders was conducted on 8/28/25 at 10:07 AM. The review revealed the order was for Senna-S (Sennosides-Docusate Sodium 8.6-50 mg). LPN #18 was interviewed on 8/28/25 at 11:21 AM. During the interview, Resident #51's medical record was reviewed, and she confirmed the order was for Senna-S but administered Geri-Kot instead, which did not have the 50 mg of docusate sodium in the active ingredient. An inspection of her medication cart was also conducted and revealed that Senna-plus (Sennosides-Docusate Sodium 8.6-50 mg) was available. LPN #18 verbalized that she should have administered Senna-plus instead of Geri-Kot.2) On 8/28/25 at 9:12 AM, LPN #19 was observed during her medication administration to Resident #44. Included in the medications that she administered was Geri-Kot (Sennosides 8.6 mg) to the resident.A review of Resident #44's medical records was conducted on 8/28/25 at 10:42 AM. The review revealed the order was for Senna-S (Sennosides-Docusate Sodium 8.6-50 mg).LPN #19 was interviewed on 8/28/25 at 11:32 AM. During the interview, Resident #44's medical record was reviewed, and she confirmed the order was for Senna-S but administered Geri-Kot instead, which did not have the 50 mg of docusate sodium in the active ingredient. An inspection of her medication cart was also conducted and revealed that Senna-plus (Sennosides-Docusate Sodium 8.6-50 mg) was available. LPN #19 verbalized that she should have administered Senna-plus instead of Geri-Kot.The Director of Nursing (DON) was interviewed on 8/28/25 at 11:44 PM. During the interview, the concern was discussed with the DON that both LPN #18 and #19 administered Geri-Kot instead of the available Senna-Plus on their medication carts. These 2 medication administrations were counted as errors out of the 29 total opportunities observed during the medication administration task. The medication error rate was computed as 7%. The DON verbalized understanding and acknowledged the concern.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation and relevant document review, it was determined that the facility kitchen failed to provide residents with the meals as indicated on their meal tickets. This was evident for 3 residents (Resident #5, #65, and #33) out of 3 observed during a dinner dining observation.The findings include:On 8/19/25 at 10:16 AM during an interview Resident #6, a long-term resident of the facility, they reported the meal portions were small and sometimes the food served was not enough to eat. On 8/27/25 at 5:40 PM, a dinner observation was conducted in the A building dining room. Observation of Resident #5's meal ticket revealed a buttered dinner roll was to be included. However, the served dinner tray did not contain a dinner roll. This was confirmed by GNA Staff #10. After surveyor intervention, Staff #10 requested a buttered dinner roll from the kitchen staff.On 8/27/25 at 5:41 PM, observation of Resident #65's meal ticket revealed a buttered dinner roll was to be included. However, the served dinner tray did not contain a dinner roll. This was confirmed by GNA Staff #11. After surveyor intervention, Staff #11 requested a buttered dinner roll from the kitchen staff.On 8/27/25 at 5:42 PM, observation of Resident #33's meal ticket revealed yogurt was to be included. However, the dinner tray served did not contain yogurt. This was confirmed by GNA Staff #10. After surveyor intervention, Staff #10 requested yogurt from the kitchen staff.On 8/27/25 at 5:47 PM, the above observations were discussed with the Regional Dietary Manager (Staff #12). He stated that he and the Facility Dietary Manager were ensuring the remaining meal trays were complete.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review it was determined that the facility failed to use proper infection control strategies. This was evident for 1) one of two laundry rooms observed, and 2) while providing feeding assistance to a resident(s). The findings include: 1). A review of the facility's laundry policy and procedure revealed a statement that read, in part, “employees should don appropriate PPE (e.g. tear resistant reusable gloves, gown/apron, and/or face shield/goggles) prior to collecting, transporting, or sorting soiled linens.” On 8/25/25 at 8:35 AM during an observation of the soiled laundry room in A building, laundry aide (Staff #4) was observed in front of the washing machine with the door open. She was not wearing any PPE. When interviewed, she said her normal process was to wear gown and gloves and she pointed in the room to where they were stored but said she was busy and so did not put them on. She said she knew that she was supposed to do so. She also said she had worked at the facility for 38 years. On 8/25/25 at 8:40 AM an interview was conducted with the district manager for Health Care Services group, (Staff #5) who in a nearby office. She was informed of the observation that Staff #4 was observed without PPE when she loaded dirty laundry into the washer, and Staff #5 acknowledged the deficient practice and said she would in-service the laundry staff on the proper use of PPE. On 8/29/25 the deficient practice was reviewed with the Director of Nursing and the Nursing Home Administrator, and they provided no further evidence. 2). On 08/23/25 at 12:00 PM, a dining observation was conducted in Building A. Geriatric Nursing Assistant (GNA) Staff #13 was sitting between Resident #14 & Resident #48. Further observation revealed that GNA #13 was observed assisting Resident #14 and Resident #48 with eating. Staff #13 was feeding both residents simultaneously and did not perform hand hygiene in between assisting each of the two residents. On 08/23/25 at 12:10 PM the Director of Nursing (DON) entered the dining room and observed Staff #13 feeding both residents without practicing proper hand hygiene. The DON did not provide a comment at the time of the observation. On 08/25/2025 at 10:10 AM, during an interview, the Administrator acknowledged concerns regarding infection control. She confirmed the issue had been addressed with GNA Staff #13. Stating that education on appropriate feeding practices and hand hygiene, when assisting multiple residents, had been provided.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations and interviews, it was determined that the facility failed to ensure call systems devices were within reach and available to the residents. This was evident for one (Resident # 60,) in a random observation during a survey.The findings include: On 8/19/25 at 10:39 AM an observation was made in Resident # 60s room. The observation revealed that the resident's call system device was hooked over the wall light behind the resident's bed, approximately 5 feet off the floor. The call light was beyond the resident's reach and not accessible to the resident.On 8/19/25 at 1:52 PM a second observation was made in Resident # 60s room. The observation revealed the call light in the same place as observed at 10:39 AM. Which was out of reach for the residents and not accessible to them.On 8/19/25 at 1: 53 PM the above observation was confirmed by the infection control nurse (Staff #8). Staff #8 removed the call light from above the wall light and placed the call system on the bed within reach of resident #60.On 8/21/25 at 2:55 PM the surveyor shared this information with the DON (Director of Nursing). She confirmed that the call light should be checked during 2-hour resident rounds to ensure that it is in reach of the resident.